
**IMMUNIZATION RECORD REQUEST**

*Standard form will be returned in 14 business days - $15 per form*

*Expedited forms (2 business days) - $30 per form*

DATE: _____PHYSICIAN: _____

PATIENT'S NAME: _____TELEPHONE: _____

PATIENT'S ADDRESS: _____

_____

**Please indicate how you would like this information sent:**

**FAX TO:**

Name of parent, school or day care center: _____

Attention: _____

Fax number of parent, school or day care center:_____

**MAIL TO (Please check one):**

_____Home _____School or Day Care

Address of School or Day Care Center: _____

_____

_____ _____

Parent/Guardian Signature Date

**We will do our best to accommodate a 7 day turnaround. If you need your forms in a specified time period, please make a notation on this form.*

10807 FALLS ROAD, SUITE 200, LUTHERVILLE, MD 21093 PHONE: (410) 321-9393 FAX: (410) 825-4945

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